



INDIANA'S FORENSIC TREATMENT PROGRAM





Recovery Model

Adapted from:

 SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery

Publisher: SAMHSA

Publication ID: PEP12-RECDEF

 New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. (Final Report)

Publisher: HHS

Publication ID: SMA-03-3832





Presenter

Michael Ross, MSW, LCSW

Email: Michael.Ross@fssa.IN.gov

Phone: (317) 234-9746

Recovery Works

Forensic Treatment Services Program Director

Division of Mental Health and Addictions







Outline

- 1. Learning Objectives
- 2. Recovery Model
- 3. Ten Fundamental Components of Recovery
- 4. Four Major Dimensions that Support a Life in Recovery
- 5. The Way Forward





Learning Objectives



(Substance Abuse Mental Health Service Administration, 2016)

- Be able to DEFINE Recovery and Resilience.
- Know the TEN Fundamental Components of the Recovery Model.
- Know the FOUR major dimensions that support a life in recovery.
- 4. Be able to EXPLAIN the importance of the Recovery Model.





Recovery Model

 A non-linear process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.





Recovery-Oriented Systems of Care

 Recovery-Oriented Systems of Care (ROSCs) are designed to help individuals recover from behavioral health problems across their lifespan by allowing choice, enhancing agency, and improving collaboration.





Recovery

In the final report of the New Freedom Commission on Mental Health:

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.





Resilience

In the final report of the New Freedom Commission on Mental Health:

Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses — and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely knit communities and neighborhoods are also resilient, providing supports for their members.

(New Freedom Commission Report, 2003)





Ten Fundamental Components of Recovery

- 1. Recovery emerges from hope
- 2. Recovery is person-driven
- Recovery occurs via many pathways
- 4. Recovery is holistic
- 5. Recovery is supported by peers and allies
- 6. Recovery involves individual, family, and community strengths and responsibility

- 7. Recovery is supported through relationship and social networks
- 8. Recovery is culturally-based and influenced
- Recovery is supported by addressing trauma
- 10. Recovery is based on respect

(Substance Abuse Mental Health Service Administration, 2013)





Recovery emerges from hope

 The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.



Recovery emerges from hope

(continued)

 Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.





Recovery is person-driven

 Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals.





Recovery is person-driven

(continued)

 Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience.





Recovery occurs via many pathways

 Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experience—that affect and determine their pathway(s) to recovery.





Recovery occurs via many pathways (continued)

 Recovery is nonlinear, characterized by continual growth and improved functioning that may involve setbacks.





Recovery occurs via many pathways (continued)

 Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faithbased approaches; peer support; and other approaches.





Recovery is holistic

 Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.





Recovery is supported by peers and allies

 Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.





Recovery is supported by peers and allies (continued)

 By fostering collaboration professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths.



Recovery involves individual, family, & community strengths and responsibility

 Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves.



FANTINE SERVICES

Recovery is supported through relationship & social networks

 An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.





Recovery is culturally-based and influenced

 Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery.





Recovery is supported by addressing trauma

• The experience of <u>trauma</u> (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues.





Recovery is based on respect

 Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery.



Four major dimensions that support a life in recovery

Dimensions of Recovery



- 1. Health
- 2. Home
- 3. Purpose
- 4. Community

(Substance Abuse Mental Health Service Administration, 2013)

MILY & SOC





Medical Model

- Professional in charge
- Focus on illness and dysfunction
- Focus on disability and lack of competence
- Directive
- Tends to be reductionistic
- Linear

Recovery Model

- Client centered
- Focus on wellness and function
- Focus on ability and competence
- Collaborative
- Tends to be holistic
- Non-linear





It is critical that treatment professionals and communities develop coalitions to reduce stigma and promote the role of resilience, resistance, and recovery in prevention, health promotion, and treatment.





Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness and recovery.





- What does an unsuccessful program look like?
- What does a successful program look like?





Questions

Email Recovery. Works@fssa. IN.gov





REFERENCES

- 1. The World Health Report: 2001. Mental Health: New Understanding, New Hope.
- 2. Nullis, Clare (Associated Press Writer) 2001, WHO Urges Greater Recognition of Mental Health
- 3. Problems. Canoe Health Geneva (AP), 04 October 2001.
- 4. Garmezy, N. (1991). Resilience in children's adaptation to negative life events and stressed environments. *Pediatrics Annals*, 20, 459-460, 463-466.
- 5. U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- 6. Dumont, J. and P. Ridgway. Mental health recovery: What helps and what hinders. in Southern Regional Conference on Mental Health Statistics. 2002. New Orleans, LA.
- 7. Anthony, W.A., Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal, 1993. 16: p. 11-23.
- 8. Carpinello, S.E., et al., The development of the Mental Health Confidence Scale: A measure of selfefficacy in individuals diagnosed with mental disorders. Psychiatric Rehabilitation Journal, 2000. 23: p. 236-243.
- 9. Corrigan, P.W., et al., *Recovery as a psychological construct*. Community Mental Health Journal, 1999. **35**(3): p. 231-240.
- 10. DeMasi, M.E., et al. Specifying dimensions of recovery. in Proceedings: 6th Annual National Conference on State Mental Health Agency Services Research and Program Evaluation. 1996. Alexandria, VA:
- 11. National Association of State Mental Health Program Directors (NASMHPD) Research Institute.
- 12. Ralph, R.O. and D. Lambert, *Needs Assessment Survey of a Sample of AMHI Consent Decree Class Members*. 1996, Portland, ME: Edmund S. Muskie Institute of Public Affairs, University of Southern Maine.
- 13. Carling, P.J., Return to community: Building support systems for people with psychiatric disabilities. 1995, New York: Guilford Publications.
- 14. Wong, Y.I. and P.L. Solomon, Community integration of persons with psychiatric disabilities in supportive independent housing: A conceptual model and methodological considerations. Mental Health Services Research, 2002. 4: p. 13-28.
- 15. Braitman, A., et al., Comparison of barriers to employment for unemployed and employed clients in a case management program: An exploratory study. Psychiatric Rehabilitation Journal, 1995. **19**(1): p. 3-18.
- 16. Mann, S.B., Talking through medication issues: One family's experience. Schizophrenia Bulletin, 1999. 25: p. 407-409.





REFERENCES

- 16. Sheehan, S., Is there no place on earth for me? 1982, New York: Vintage Books.
- 17. Crane-Ross, D., D. Roth, and B.G. Lauber, *Consumers' and case managers' perceptions of mental health and community support service needs*. Community Mental Health Journal, 2000. **36**: p. 161-178.
- 18. Hogan, M.F., Spending Too Much on Mental Illness in All the Wrong Places. Psychiatric Services, 2002. 53(10): p. 1251-1252.
- 19. Drake, R.E., et al., *Implementing evidence-based practices in routine mental health service settings*. Psychiatric Services, 2001. **52**: p. 179-182.
- 20. Bond, G.R., et al., Measurement of fidelity in psychiatric rehabilitation. Mental Health Services Research, 2000. 2: p. 75-87.
- 21. Becker, D.R., et al., *Fidelity of supported employment programs and employment outcomes*. Psychiatric Services, 2001. **52**: p. 834-836.
- 22. McHugo, G.J., et al., Fidelity to assertive community treatment and client outcomes in the New Hampshire dual disorders study. Psychiatric Services, 1999. **50**(6): p. 818-824.
- 23. McGrew, J.H., et al., Measuring the fidelity of implementation of a mental health program model. Journal of Consulting and Clinical Psychology, 1994. 62: p. 670-678.
- 24. Jerrell, J.M. and M.S. Ridgely, *Impact of robustness of program implementation on outcomes of clients in dual diagnosis programs*. Psychiatric Services, 1999. **50**: p. 109-112.
- 25. McDonnell, J., et al., An analysis of the procedural components of supported employment programs associated with employment outcomes. Journal of Applied Behavior Analysis. Special Issue: Supported employment, 1989. 22(4): p. 417-428.
- 26. Lehman, A.F. and D.M. Steinwachs, *Patterns of usual care for schizophrenia: Initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey.* Schizophrenia Bulletin, 1998. **24**: p. 11-20.
- 27. Drake, R.E., et al., *Implementing evidence-based practices in routine mental health service settings*. Psychiatric Services, 2001. **52**: p. 179-182.
- 28. Lehman, A.F. and D.M. Steinwachs, *Patterns of usual care for schizophrenia: Initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey.* Schizophrenia Bulletin, 1998. **24**: p. 11-20.
- 29. Lehman, A.F. and D.M. Steinwachs, *Translating research into practice: The Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations.* Schizophrenia Bulletin, 1998. **24**: p. 1-10.
- 30. Copeland, M.E., Wellness Recovery Action Plan. 1997, Brattleboro, VT: Peach Press. Chichester. p. 91-109.
- 31. Mueser, K.T., et al., *Illness management and recovery for severe mental illness: A review of the research.* Psychiatric Services, 2002. **53**(10): p. 1272-1284.